Patient No:

Candy Skull Aesthetics

KENALOG * CONSULTATION FORM

PERSONAL INFORMATION: **DATE:**

FIRST NAME

LAST NAME

ADDRESS

CITY

POSTCODE

DATE OF BIRTH

COUNTY

PHONE

HEIGHT [CM]

WEIGHT [KG]

EMAIL

YES NO

(Your email address will be used for appointment confirmations, and quarterly newsletters)
If you would like to subscribe to our newsletter and promotions please select YES or NOT

HOW DID YOU HEAR ABOUT US?

WORD OF MOUTH LEAFLET INTERNET OTHER

For your client records, do we have permission to take before and after photographs?

YES NO

MEDICAL HISTORY

Do you suffer from any of the following diseases?
[Please check all of the boxes that apply.]

- ☐ Heart Conditions
- ☐ Pacemaker
- ☐ Muscular Conditions
- ☐ Cancer
- ☐ Recent Infections [Tuberculosis etc]
- ☐ Auto-Immune Conditions
- ☐ Kidney/Liver Disorders
- ☐ Asthma/COPD
- ☐ High/Low Blood Pressure
- ☐ Arthritis
- ☐ Thrombosis/Phlebitis
- ☐ Transplant
- ☐ Water Retention
- ☐ Thyroid Disorders
- ☐ Blood Thinners
- ☐ Glaucoma
- ☐ Diabetes
- ☐ Pregnancy/Breastfeeding
- ☐ Epilepsy
- ☐ Other

If your answer is "Yes", please describe details:

Are you taking any of the medications or supplements listed below?

- ( ) Omega 3 Fatty Acids
- ( ) Anti-depression medication
- ( ) Flax seed oil
- ( ) Vitamin E
- ( ) Aspirin
- ( ) Other

Have you ever had an allergic/intolerances any reaction?

- ( ) Yes
- ( ) No

If your answer is "Yes", please describe details:

CLIENT PROFILE/SYMPTOMS

By completing this client profile, you will assist us in evaluating you and your specific concerns. The information you will provide will be used to determine what factors may be affecting you so that we may recommend the proper treatment care.

On a scale of 1 - 10 how severe are your symptoms (1 being mild, 10 being severe):

- Sneezing and coughing: 1 2 3 4 5 6 7 8 9 10
- Runny or blocked nose: 1 2 3 4 5 6 7 8 9 10
- Itchy, red or watery eyes: 1 2 3 4 5 6 7 8 9 10
- Ithcy throat, mouth, nose and ears: 1 2 3 4 5 6 7 8 9 10
- Loss of smell: 1 2 3 4 5 6 7 8 9 10
- Pain around temples and forehead: 1 2 3 4 5 6 7 8 9 10
- Headache: 1 2 3 4 5 6 7 8 9 10
- Earache: 1 2 3 4 5 6 7 8 9 10
- Feeling tired: 1 2 3 4 5 6 7 8 9 10
- Mucus running down the back of the throat: 1 2 3 4 5 6 7 8 9 10

When do your symptoms appear ?

○ Spring ○ Summer ○ All year round

○ I hereby give permission to perform this and all subsequent Kenalog Hayfever treatments.

Signature of the Patient _____

DATE: _____